

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **3894**
Registrar's No. **161**

FILED FEB 20 1950
BIRTH NO. **290-50** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buch.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		d. STREET ADDRESS (If rural, give location) 3308 1/2 St. Joseph, Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Deborah b. (Middle) Sue c. (Last) Buckley		4. DATE OF DEATH (Month) (Day) (Year) Jan. 30, 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Jan. 26, 1950
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 4 11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri
13a. FATHER'S NAME Donald Emory Buckley		13b. MOTHER'S MAIDEN NAME Dortha Maxine Wilson	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Donald Buckley - St. Joseph, Mo.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suffocation ANTECEDENT CAUSES (b) Aspiration of mucus and vomitus into bronchi - II. OTHER SIGNIFICANT CONDITIONS Possibly there was some Congenital anomaly - but there was no evidence.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Joseph Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 46
22. I hereby certify that I attended the deceased from 1-26, 1950, to 1-30, 1950, that I last saw the deceased alive on 1-29, 1950, and that death occurred at 10:45p m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) D. Grant M.D.		23b. ADDRESS St. Joseph Mo	23c. DATE SIGNED 2-4-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-1-50	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
DATE REC'D BY LOCAL REG. Feb. 14, 1950		REGISTRAR'S SIGNATURE E. C. Jenkins	
		25. FUNERAL DIRECTOR'S SIGNATURE Stamey Funeral Home	
		ADDRESS St. Joseph, Missouri	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Student Embalmer No.

working under my personal supervision.

Signed.....

Charles M. Harman

Signed.....

Student Embalmer

Licensed Embalmer No. *4487*

P. O. Address.....

St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.